

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06698

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>409 Old Philadelphia Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARL AUGUST FRANK ANDERSON</u>		4. DATE OF DEATH <u>MAY 17 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 5, 1905</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Pipe Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.-Ret.</u>	
11. BIRTHPLACE (State or foreign country) <u>Joppa, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl A. Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-7276</u>	
17. INFORMANT <u>DOROTHY ANDERSON (WIFE)</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip W. Heuman</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>MAY 17, 1967</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 1967</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		24a. REC'D BY REGISTRAR <u>MAY 19 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02712

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STATE OF MARYLAND
DEPARTMENT OF HEALTH

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is mostly blank with some faint markings.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06713

CERTIFICATE OF DEATH

06699

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				d. STREET ADDRESS <u>400 South Main Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GRACE MADELINE Bailey</u>				4. DATE OF DEATH <u>MAY 13 1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 1, 1921</u>	
				9. AGE (In years lost birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD (Harford Co.)</u>	
13. FATHER'S NAME <u>W. SANNER Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Viola Preston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-12-9257</u>		17. INFORMANT (Print name) <u>Mr. Tom Bailey</u> Address <u>12 Forest Drive Bel Air, Maryland 21014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemic Shock</u> DUE TO <u>Gram-Negative Bacteria + Enteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8 days</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laennec's pneumonia (2) Dehydration + hypokalemia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 12, 1967</u> , to <u>MAY 13, 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 13, 1967</u> , and that death occurred at <u>30 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Lee, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>				22d. ADDRESS <u>Haure de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Bel Air, Harford Co, Maryland 21014</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>				ADDRESS <u>W. Broadway & Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR DATE <u>16 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06714

CERTIFICATE OF DEATH

06700

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>			d. STREET ADDRESS <u>124 Wilson St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>Josephine</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1967</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 28, 1902</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>	
13. FATHER'S NAME <u>WILLIS JACOBS</u>			14. MOTHER'S MAIDEN NAME <u>GEORGINA BOYD</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>216-46-8262</u>		17. INFORMANT <u>M. FOREST E. BROWN</u> Address <u>124 WILSON ST. HAVRE DE GRACE MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular</u> DUE TO (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3-4 days</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>		
21. I certify that (I) (this hospital) attended the deceased from <u>5/24, 1967</u> to <u>MAY 27, 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 27, 1967</u> , and that death occurred at <u>10 P.</u> M. from causes and on the date stated above.					
22a. SIGNATURE <u>Edward C. Foo, M.D.</u>		22b. DATE SIGNED <u>5/29/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>	
22d. ADDRESS <u>Havre de Grace, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>MAY 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL GARDENS</u>	23d. LOCATION (City or town) (County) (State) <u>HARFORD Co. MD.</u>		
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD</u>		25a. REC'D BY REGISTRAR <u>JUN 1 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06715

CERTIFICATE OF DEATH

06701

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Arsenal	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS 6201 C Baker Circle	
3. NAME OF DECEASED (Type or print) First Lisa Middle (none) Last CLARK		4. DATE OF DEATH Month May Day 17 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1967
9. AGE (In years lost birthday) yrs. 16		10. IF UNDER 1 YEAR Months 16 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Harford, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roosevelt Clark		14. MOTHER'S MAIDEN NAME Minnie R. Bottoms	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Mother		Address (Same as above)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 16 hrs 45 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that this (this hospital) attended the deceased from 16 May , 19 67 , to May 17 , 19 67 that it (we) lost saw the deceased alive on May 17 , 19 67 , and that death occurred at 12:55 a.m. , from causes and on the date stated above.			
22a. SIGNATURE Thomas J. Green		22b. DATE SIGNED 17 May 1967	
22c. PHYSICIAN'S NAME (Type) THOMAS J. GREEN, CPT, MC		22d. ADDRESS Kirk Army Hospital, APG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY A.P.G. Post Cemetery		23d. LOCATION (City or Town) (County) (State) Aberdeen Proving Ground, Md.	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 29 1967	

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Synthesizing, *Organizing*

Cooperative Bank

WILLIAM J. HAYES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06716

CERTIFICATE OF DEATH

06702

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>44 Fenway St.</u>	
3. NAME OF DECEASED (Type or print) <u>MARIE F. COPELAND</u>		4. DATE OF DEATH <u>MAY 16 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-22</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air-force Employee</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Brown</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>231-22-3346</u>	
17. INFORMANT <u>Mr. John E. Copeland, Aberdeen, Md.</u>		Address <u>44 Fenway St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Myocardial Infarction</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1966</u> to <u>MAY 16, 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 16 1967</u> , and that death occurred at <u>10:30 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>5/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Christian Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Holland Virginia</u>
24. FUNERAL DIRECTOR <u>Amos E. Bullard</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 22 1967</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06717

CERTIFICATE OF DEATH

06703

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air			c. LENGTH OF STAY IN 1b 1 yr. 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Convalescing Home				d. STREET ADDRESS 404 Giles Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IRIS First IRIS Middle V. Last CULLUM				4. DATE OF DEATH Month MAY Day 17 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1880	
9. AGE (In years lost birthday) yrs. 86		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Kyle				14. MOTHER'S MAIDEN NAME Annie Bird			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-54-9070-T		17. INFORMANT Mrs. Flossie V. Hooper, 404 Giles St., Address Bel Air, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, terminating DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) Chronic Hypertensive ASCVD							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/14/ 1956 , to 5/17 1967 , that (I) (see) last saw the deceased alive on 5/16/ 1967 , and that death occurred at 10 a.m. from causes and on the date stated above.							
22a. SIGNATURE Willard P. Hudson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/18/1967	
22c. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				22d. ADDRESS Forest Hill, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009				25a. REC'D BY REGISTRAR MAY 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06718

CERTIFICATE OF DEATH

06704

1. PLACE OF DEATH a. COUNTY Hanford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 3807 Fleetwood Balti. b. COUNTY Balti.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hayre de Grace		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brevin Nursing Home		d. STREET ADDRESS 4215 Union St	
3. NAME OF DECEASED (Type or print) Charlotte Ann Cundiff		4. DATE OF DEATH Month 5- Day 18 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1893
9. AGE (In years last birthday) 74 yrs.		10. BIRTHPLACE (County & State, or foreign country) Knoxville Tenn	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm C Sheen		14. MOTHER'S MAIDEN NAME Jane T Bowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-10-2428	
17. INFORMANT Brevin		Address 4215 Union St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary-vascular thrombosis DUE TO (b) Arteriosclerosis generalis DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/10/1967 to 5/18/1967 that (I) (we) last saw the deceased alive on 5/18/1967 and that death occurred at 12 M, from causes and on the date stated above.			
22a. SIGNATURE Chas. Judge		22b. DATE SIGNED 5/18/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-22-1967	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Lassahn Funeral Home		25a. REC'D BY REGISTRAR MAY 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06713

06705

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVERDE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVERDE GRACE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD Memorial Hospital		d. STREET ADDRESS 240 Bloomsbury Ave.	
3. NAME OF DECEASED (Type or print) DAVID R. Curry		4. DATE OF DEATH Month MAY Day 6 Year 1967	
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 11, 1911
9. AGE (In years (last birthday) yrs. 56)		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOLT & FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY DISABILITY	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE A. CURRY		14. MOTHER'S MAIDEN NAME SARAH JANE MORRIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-18-3970	
17. INFORMANT Latitia M. Curry, HAVERDE GRACE MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) MYOCARDIAL INFARCTION DUE TO (c) ASCVD		INTERVAL BETWEEN ONSET AND DEATH HOURS HOURS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5/5 , 19 67 , to 5/6 , 19 67 , that (I) (we) last saw the deceased alive on MAY 6 19 67 , and that death occurred at 3:35 M, from causes and on the date stated above.			
22a. SIGNATURE Alcyon Vidal		22b. DATE SIGNED 5-6-67	
22c. PHYSICIAN'S NAME (Type) S. LEYTE-VIDAL		22d. ADDRESS 1140 BELAIR AVE. ABERDEEN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 10, 1967	23c. NAME OF CEMETERY OR CREMATORY ASBURY CEM.	23d. LOCATION (City or Town) (County) (State) Cecil Co. MD.
24. FUNERAL DIRECTOR K. Madison Mitchell, Haverde Grace, Md.		25a. REC'D BY REGISTRAR MAY 10 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

06706

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street			c. LENGTH OF STAY IN 1b 33 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prospect Road				d. STREET ADDRESS Prospect Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First IRENE Middle T. Last DAVIS				4. DATE OF DEATH Month May Day 22 , Year 19 67				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1903		
9. AGE (In years last birthday) yrs. 64		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Delta, Pa.		
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Samuel Tarbert				
14. MOTHER'S MAIDEN NAME Mary Grimes				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				
16. SOCIAL SECURITY NO. 220-12-4272				17. INFORMANT Address Thomas S. Davis, Street, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Advanced Arteriosclerosis + cerebral Thrombosis DUE TO (c) Right perinephric abscess + non-functioning kidney							INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mo. 8 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension - Mucoid pneumonia (3 days)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 57 , to 22 May , 19 67 , that (I) (we) last saw the deceased alive on 22 May , 19 67 , and that death occurred at 4:35 P.M. , from causes and on the date stated above.								
22a. SIGNATURE Edwin W. Whiteford, Jr. M.D.				22b. DATE SIGNED May 23, 1967		22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr. M.D.		
22d. ADDRESS Whiteford, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 25, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Vernon		23d. LOCATION (City or Town) (County) (State) Whiteford, Harford, Md.		
24. FUNERAL DIRECTOR John H. Harkins				25a. REC'D BY REGISTRAR DATE MAY 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06721

CERTIFICATE OF DEATH

06708

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Street		c. LENGTH OF STAY IN 1b 46 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Doyle Road		d. STREET ADDRESS Doyle Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J. Middle KEMMETT Last DOYLE		4. DATE OF DEATH Month May Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1888
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Public Schools	
11. BIRTHPLACE (County & State, or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas J. Doyle		14. MOTHER'S MAIDEN NAME Mary M. Frederick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-36-0209	
17. INFORMANT Thomas F. Doyle, Street, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Advanced atherosclerotic cardiovascular disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1.5 min 6 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Exogenous obesity, osteoarthritis - knees - spastic colon		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 19 60 , to 29 May , 19 67 , that (I) (we) last saw the deceased alive on 22 May , 19 67 , and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Edwin W. Whiteford, Jr.		22b. DATE SIGNED May 31, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr. MD		22d. ADDRESS Whiteford, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Emory	23d. LOCATION (City or Town) (County) (State) Street, Harford Co., Md.
24. FUNERAL DIRECTOR John H. Harkins		25a. REC'D BY REGISTRAR John H. Harkins	
25b. REGISTRAR'S SIGNATURE John H. Harkins		DATE JUN 2 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06722

06709

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LAURA</u> Last <u>ERWIN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 29, 1897</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH FRANCIS CRAWFORD</u>		14. MOTHER'S MAIDEN NAME <u>LAURA V. McEWING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>217-07-7446</u>	
17. INFORMANT <u>Mrs. Virginia E. Holcomb</u>		Address <u>Abertown, Md. R.D. #1 Box 254A.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> OUER TO (c) <u>diuretic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 27, 1967</u> , to <u>May 6, 1967</u> that (I) (we) last saw the deceased alive on <u>May 6, 1967</u> , and that death occurred at <u>7:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. W. Jones</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>5/6/67</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>May 9, 1967</u>	<u>HARFORD MEMORIAL GARDENS</u>	<u>HARFORD, Co. MD.</u>
24. FUNERAL DIRECTOR <u>R. Madison Mitchell, Harford Co., Md.</u>		25a. RECEIVED BY REGISTRAR DATE <u>MAY 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05 119

RECORD OF DEATH

32720

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MAY 1981

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06723

CERTIFICATE OF DEATH

06710

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Magnolia Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Lorean May Faine</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1909</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack Martin</u>		14. MOTHER'S MAIDEN NAME <u>Crema Arrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-28-8342</u>	
17. INFORMANT <u>Mr. Troy Faine, Magnolia Rd., Joppa, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left cerebral vascular accident</u> DUE TO <u>Calcinomatosis - left</u> DUE TO <u>breast cancer.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>65</u> to <u>May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>May 4</u> 19 <u>67</u> , and that death occurred at <u>9:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>W.H. Sadowsky</u> M.D.		22b. DATE SIGNED <u>5/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.H. SADOWSKY</u>		22d. ADDRESS <u>504 LEWIS ST. Harford, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Aberdeen R.D. Harford Md</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

VR A15ME
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06724

06711

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hartford</u> c. LENGTH OF STAY IN 1b <u>4 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hartford</u> d. STREET ADDRESS <u>614 Chapel Terrace</u>			
3. NAME OF DECEASED (Type or print) <u>Grace Farrell</u>				4. DATE OF DEATH <u>May 2 1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/21/1895</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Cairns</u>				14. MOTHER'S MAIDEN NAME <u>Grace McGeary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>unk.</u>			
17. INFORMANT <u>Dr. Farrell</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> e.m. <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Ar. W.</u>			
EXAMINER'S NAME (Type) <u>Gerald Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>5/6/67</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>				22d. LOCATION (City, town, or county) (State) <u>Hartford Md</u>			
23. FUNERAL DIRECTOR <u>William H. Palmer</u>				24a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>Hartford Md</u>				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MAY 8 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH										06712	
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Churchville				c. LENGTH OF STAY IN 1b 2 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville RD #1 Box 627				d. STREET ADDRESS Rockdale Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rockdale Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Grant Hazel Good			First Middle Last			4. DATE OF DEATH May 2, 1967			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/1906		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Gen. farming		11. BIRTHPLACE (County & State, or foreign country) Pocahontas Co. W.Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Kenny Newton Good						14. MOTHER'S MAIDEN NAME Maudie Ann Morrison					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-12-5814		17. INFORMANT Opal A. Good			RD #1 Address Box 627 Churchville, Md. 21028		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic coronary artery disease (c) Arteriosclerotic coronary artery disease DUE TO (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 24 hr 15 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Gastric carcinoma & obstruction at esophageal area											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Oct 1957 to 2 May 1967 , that (I) (we) last saw the deceased alive on 2 May 1967 , and that death occurred at 8:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Edwin W. Whiteford Jr. M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3 May 1967		
22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford Jr.						22d. ADDRESS Whiteford, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/5/1967		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION (City, town or county) (State) Bel Air Maryland					
24 FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz						ADDRESS Jarrettsville, Md.		25a. REC'D BY REGISTRAR May 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Christie's No. 1 Box 627

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06726

06713

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hanford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hanford Memorial Hospital</u>			d. STREET ADDRESS <u>36 Hanover Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Roosevelt</u> Middle <u>Gregory</u> Last <u>Trr</u>			4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-47</u>	9. AGE (In years lost birthday) <u>19</u> yrs.	10. UNDER 1 YEAR Months <u>12</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.,</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. EATHER'S NAME <u>Roosevelt A. Gregory Sr.</u>		
14. MOTHER'S MAIDEN NAME <u>Mary M. Mayo</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>224-66-6211</u>			17. INFORMANT <u>Wife, Same as 2 C & D.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fork lifted over turned on him</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> p.m. <u>5-11-67</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Moore's Store</u>	20f. (City or town) <u>Aberdeen</u>	(County) <u>Hanford</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Boia</u>			
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Boia</u>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county) <u>5-12-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>14 May 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>South Hill Cemetery</u>	23d. LOCATION (City or Town) <u>South Hill, Virginia</u>	(County)	(State)
24. FUNERAL DIRECTOR <u>Webster Macaulay Jr.</u>		25a. REC'D BY REGISTRAR <u>Tarring Funeral Home</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>	

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THE UNIVERSITY OF CHICAGO
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540 EAST 58TH STREET
CHICAGO, ILL. 60637
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06727

CERTIFICATE OF DEATH

06714

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>P.O. Box 62</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES HARRY HANNA</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 11, 1885</u>	
9. AGE (In years lost birthday) yrs. <u>81</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>auto accessories</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Calvin H. Hanna</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kincaid</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>27A-20-7219</u>		17. INFORMANT Address <u>Mrs. Vera G. Hanna, Box 62, Bel Air, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO <u>492x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Thrombosis + A.S.C.D.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 11, 1967</u> , to <u>MAY 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 16, 1967</u> , and that death occurred at <u>8:25 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Foo, M.D.</u>				22b. DATE SIGNED <u>5/16/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward C. Foo, M.D.</u>	
22d. ADDRESS <u>Harford de Grace, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>				25a. RECEIVED BY REGISTRAR DATE <u>MAY 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Orin Jones Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

10000

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "HAWAII" and "1962" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06723					06715				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Harford					Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b				
Aberdeen Proving Ground					DOA				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
Kirk Army Hospital					6508 Hawthorne Drive				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Everette Eugene Hicks					May 8 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		27 June 35		31 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Soldier				US Army		Prescott, Arkansas		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
George W. Hicks					Laura Smith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
Yes					Feb 55 - May 67		578-48-8582 Personnel Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct(?) 4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Myocarditis(?) (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that 10 (this hospital) attended the deceased from 8 May 1967, to 8 May 1967, that 10 (we) last saw the deceased alive on 8 May 1967, and that death occurred at 5:00 a.m. from the causes and on the date stated above.									
22a. SIGNATURE Thomas Fraher MD					22b. DATE SIGNED 8 May 1967		22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, M.D.		
22d. ADDRESS Kirk Army Hospital, APG, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF May 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		23d. LOCATION (City, town or county) (State) Prescott, Arkansas		
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.					25a. REC'D BY REGISTRAR MAY 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

00113

00113

1. The first of the three...
2. The second of the three...
3. The third of the three...
4. The fourth of the three...
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49. The forty-ninth of the three...
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59. The fifty-ninth of the three...
60. The sixtieth of the three...
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69. The sixty-ninth of the three...
70. The seventieth of the three...
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80. The eightieth of the three...
81. The eighty-first of the three...
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89. The eighty-ninth of the three...
90. The ninetieth of the three...
91. The ninety-first of the three...
92. The ninety-second of the three...
93. The ninety-third of the three...
94. The ninety-fourth of the three...
95. The ninety-fifth of the three...
96. The ninety-sixth of the three...
97. The ninety-seventh of the three...
98. The ninety-eighth of the three...
99. The ninety-ninth of the three...
100. The hundredth of the three...

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05716

06723

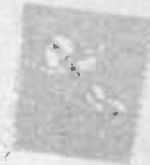
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURACIA GRACE</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>Box 42</u>	
3. NAME OF DECEASED (Type or print) <u>Charles GROVER</u>		4. DATE OF DEATH <u>May 1 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 April 1885</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electro Type & Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD. (Balto.)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Casper Hiob (D)</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Kampe (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-8769-A</u>	
17. INFORMANT <u>Wife, Same as 2 C & D.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia and</u> 4500 DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 yr</u> <u>5 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1960</u> , to <u>May 1, 1967</u> that (I) (we) last saw the deceased alive on <u>May 1 1967</u> , and that death occurred at <u>4:45 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips</u>		22b. DATE SIGNED <u>5/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>DARLINGTON MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Paul Lutheran Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Aberdeen, Md.</u>
24. FUNERAL DIRECTOR <u>Walter Macoucher Sr.</u>		25. REC'D BY REGISTRAR <u>May 4 1967</u>	
25a. ADDRESS <u>Aberdeen, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

RECEIVED

10000



Handwritten text at the bottom of the page, including a signature and some illegible notes.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06730

CERTIFICATE OF DEATH

06717

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Three-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		d. STREET ADDRESS <u>38 Granite Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John F. Holland</u>		4. DATE OF DEATH Month <u>5</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1907</u>
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR: Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John F. Holland, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Minnie L. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>557-32-1505</u>	
17. INFORMANT <u>Cecil E. Holland, 8364 Jefferson St., N.E.</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Aneurysm</u> (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 months</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 12, 1967</u> to <u>May 8, 1967</u> that (I) (we) last saw the deceased alive on <u>May 8, 1967</u> , and that death occurred at <u>5:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.		22b. DATE SIGNED <u>May 13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson, M.D.</u>		22d. ADDRESS <u>Port Deposit, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 18, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Lee. A. Patterson & Son</u> ADDRESS <u>Perryville, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 19 1967</u>	

02730

EXTRACT OF DEED

02730

Sept. 25, 1907

John F. Johnson

John F. Johnson

John F. Johnson

17-2-107

John F. Johnson

John F. Johnson

May 10, 1907

John F. Johnson

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06731

06718

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>				c. LENGTH OF STAY IN 1b <u>Admission</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DCHA Hartford Memorial Hospital</u>				e. STREET ADDRESS <u>47 Bush Chapel Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Douglas</u> Middle <u>Hurdley</u> Last <u>Atterden</u>				4. DATE OF DEATH Month <u>May</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Neuro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 25, 1907</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Odd jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>No record</u>	
14. MOTHER'S MAIDEN NAME <u>No record</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>224-22-7180</u>		17. INFORMANT <u>Mrs. Mary Eliza Hurdley-Atterden, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald P Palmer</u>				M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. J. W.</u>			
EXAMINER'S NAME (Type) <u>Gerald P Palmer</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>May 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>	
23d. LOCATION (City, town or county) (State) <u>Atterden, Hartford Co. Md.</u>				24. FUNERAL DIRECTOR <u>Otelia J Bullock, Starvede Hwy, Md.</u>			
25a. REC'D BY REGISTRAR DATE <u>MAY 8 1967</u>				25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

100-7

100-7

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06732

CERTIFICATE OF DEATH

05719

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none		d. STREET ADDRESS 2821 Willoughby Beach Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle AUGUST Last KERSHAW		4. DATE OF DEATH Month May Day 11 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1890
9. AGE (In years) Last birthday 76 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt - Ret.	
11. BIRTHPLACE (County & State, or foreign country) Detroit, Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Kershaw		14. MOTHER'S MAIDEN NAME Mary Boelter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 220-20-7979	
17. INFORMANT Mrs. Edna Viola Kershaw, 2821 Willoughby Beach Road		Address Edgewood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE FAILURE DUE TO (b) HYPERTENSIVE ARTERIO SCLEROTIC CARDIO- VASCULAR DISEASE DUE TO (c) 12 YRS INTERVAL BETWEEN ONSET AND DEATH 30 MIN OVER			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 433X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 13, 1964 to MAY 11, 1967 that (I) (we) last saw the deceased alive on MAY 11 1967 , and that death occurred at 7:55 A.M. from causes and on the date stated above.			
22a. SIGNATURE Philip W. Heuman		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Philip W. Heuman, M.D.		22d. ADDRESS 307 Hickory Avenue, Bel Air, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 15, 1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a. REC'D BY REGISTRAR 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

00110

STATE OF TEXAS

00110

MAINTAIN OR REPAIR SUBJECT PROPERTY AT ALL TIMES
TO BE MAINTAINED IN GOOD ORDER
TO BE MAINTAINED IN GOOD ORDER
TO BE MAINTAINED IN GOOD ORDER

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06720

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Winston Thomas Kourey</u>		4. DATE OF DEATH <u>May 3 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/1927</u> 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BALTO TRANSIT CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRANSPORTATION</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SALEM W. KOUREY</u>		14. MOTHER'S MAIDEN NAME <u>HELEN MEYER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>219-22-8165</u>	
17. INFORMANT <u>DR. SALEM W. KOUREY (SAME)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Sclerosis</u> 345X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel A. ...</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>5-3-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/6/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>		25a. REC'D BY REGISTRAR <u>May 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1990

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
06734					06721					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			Harford		a. STATE			Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Joppa,		b. COUNTY			Harford		
c. LENGTH OF STAY IN 1b			1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Joppa		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM?		
none					1407 Old Joppa Road			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last					Month Day Year					
Mamie May Limbert					May 9 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years, last birthday)		
F		W				June 4, 1892		74 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Dress Maker			Mfg.			Tower City, Pa.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
John Shomper					Tammie Morgan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT					
no			162-07-8362		Irvin Limbert, 1407 Old Joppa Rd., Joppa, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular occlusion DUE TO Cardiac Failure (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)								INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?		
Per Minson is -								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Jan. 1967, to May 1967, that (I) (we) last saw the deceased alive on May 9 1967, and that death occurred at 1030 M, from the causes and on the date stated above.										
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
William A. Tyson					M.D.		5-9-67			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
William A. Tyson					Kingsville Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Removal			May 10, 1967		Buffington Funeral Home		Valley View, Pa.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE
Howard K. McComas & Son, Abingdon, Md. 21009					MAY 11 1967					Charles Judge

1592-1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06735

06722

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrod Chase</u>		c. LENGTH OF STAY IN 16 <u>35 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harrod Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Citizens Nursing Home</u>				d. STREET ADDRESS <u>701 S. Washington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Winkler Maloney</u>				4. DATE OF DEATH Month Day Year <u>5/14/67</u> <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>5/25/1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wilmington Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas R. Winkler</u>				14. MOTHER'S MAIDEN NAME <u>Ida J. Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT Address <u>Mrs. Lucy McMaster Harrod Chase, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> DUE TO (b) <u>Malignancy of G.I. tract</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2-3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>A.S.C.V.D. and Nutritional Anemia + Hypoproteinemia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 10th, 1967</u> , to <u>5/13th, 1967</u> , that (I) (we) last saw the deceased alive on <u>5/13th, 1967</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loomis</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loomis</u>				22d. ADDRESS <u>Harrod Chase, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Primrose</u>		23d. LOCATION (City, town or country) (State) <u>Wilmington, Del.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Primrose Pm, Harrod Chase, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAY 17 1967

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTERED NURSE IN CHARGE OF THE NURSING HOME OR THE PHYSICIAN IN CHARGE OF THE HOSPITAL OR THE CLINIC IN WHICH THE PATIENT IS RECEIVING TREATMENT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06736

CERTIFICATE OF DEATH

06723

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Burlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. LENGTH OF STAY IN 1b N/A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willingboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital				d. STREET ADDRESS 16 Gamewell Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James D. MATTHEWS		4. DATE OF DEATH Month May Day 15 Year 19 67		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1947		9. AGE (In years last birthday) 19 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James J. Matthews				14. MOTHER'S MAIDEN NAME Dorothy Anderson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 15 May 67		16. SOCIAL SECURITY NO. 230-66-8322		17. INFORMANT DA 41 Personnel Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Automobile Accident (c) Automobile Accident						INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was a passenger in an auto involved in an accident.					
20c. TIME OF INJURY Month May Day 15 Year 19 67 Hour 1:00 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) JFK Hwy Rte 95		20f. (City or town) (County) (State) Whitemarsh, Baltimore, Md.	
21. I certify that the (this hospital) attended the deceased from 15 May , 19 67 , to 15 May , 19 67 , that we (we) last saw the deceased at an DOA 15 May 1967 , and that death occurred at 2:00 AM , from causes and on the date stated above.							
22a. SIGNATURE Thomas Fraher MD				22b. DATE SIGNED 15 May 1967		22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, M.D.	
22d. ADDRESS Kirk Army Hospital, APG, Md.				22e. ADDRESS Kirk Army Hospital, APG, Md.		22f. ADDRESS Kirk Army Hospital, APG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 17 May 67		23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		23d. LOCATION (City or Town) (County) (State) Mt Holly, New Jersey	
24. FUNERAL DIRECTOR Wesley Maccocher Sr.				25a. REC'D BY REGISTRAR MAY 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
26. FUNERAL HOME Tarring Funeral Home, Aberdeen, Md.							

02736

REMARKS OF CASE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06737

06724

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground c. LENGTH OF STAY IN 1b 7 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS Rt 3 Box 311 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY		First L.		Middle MILLER		Last MAY		4. DATE OF DEATH Month MAY Day 7 Year 19 67	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19 February 1918		9. AGE (In years last birthday) 48 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurants		11. BIRTHPLACE (County & State, or foreign country) Harford Maryland		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Edward Mathews				14. MOTHER'S MAIDEN NAME Lillian Wolfington					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-9734		17. INFORMANT 311 Address CLAUDE MILLER, Rt 3 Box 311, Aberdeen, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular Accident 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 7 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Aberdeen		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 May , 19 67 , to 7 May , 19 67 , that (I) (we) last saw the deceased alive on 7 May , 19 67 , and that death occurred at 6:15 PM , from the causes and on the date stated above.									
22a. SIGNATURE Thomas Fraher MD				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7 May 67			
22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, MD				22d. ADDRESS Kirk Army Hospital, APG, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 May 67		23c. NAME OF CEMETERY OR CREMATORY Grove Cemetery		23d. LOCATION (City, town or county) Aberdeen, Maryland		(State)	
24. FUNERAL DIRECTOR Walter McCumber Sr.				ADDRESS Aberdeen, Md.		25a. REC'D BY REGISTRAR MAY 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06738

06725

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-ABERDEEN 21001				c. LENGTH OF STAY IN 1b 50 YRS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. #2 Box 308				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL-ABERDEEN 21001			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS R.D. #2 Box 308			
3. NAME OF DECEASED (Type or print) WILLIAM First OTHO Middle MILLER Last				4. DATE OF DEATH MAY 19 1967 Month 19 Day 19 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 16, 1895	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARM OWNER			
11. BIRTHPLACE (County & State, or foreign country) MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES MILLER				14. MOTHER'S MAIDEN NAME MARY BAKER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT Mrs. HATTIE E MILLER Address ABERDEEN 21001 R.D. #2 Box 308							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 432.1 Acute Congestive Cardiac Failure DUE TO (b) Advanced Chronic Ischemic CV Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ch. cholelithic							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1967 to May 19, 1967 , that (I) (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 7 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ralph Horky				22b. DATE SIGNED 7/19/67			
22c. PHYSICIAN'S NAME (Type) R. Ralph Horky				22d. ADDRESS Churchville MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 20, 1967		23c. NAME OF CEMETERY OR CREMATORY WESLEYAN CHAPEL CEM.		23d. LOCATION (City, town or county) (State) HARFORD CO. MD	
24. FUNERAL DIRECTOR'S SIGNATURE R. Madson Mitchell ADDRESS NAVIPE DE GRACE MD				25a. REC'D BY REGISTRAR MAY 22 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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RECORDS OF DEATH

MAY 22 1961

06733

10. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood Arsenal, Md.		c. LENGTH OF STAY IN 1b approx. 6 hrs. on 28 May 67	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USA Dispensary, Edgewood Arsenal		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 21215	
		d. STREET ADDRESS 2817 Ruscombe Lane	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Joseph Milloff		4. DATE OF DEATH May 28 19 67	
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1945
		9. AGE (In years last birthday) 22 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Engineer		10b. KIND OF BUSINESS OR INDUSTRY Fed. Civ. Svc.	11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David Milloff	
14. MOTHER'S MAIDEN NAME Florence Fischer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No ---	
16. SOCIAL SECURITY NO. 214-44-6561		17. INFORMANT (Uncle) Robert Fischer, Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heat stroke DUE TO (b) Thermal control failure DUE TO (c) Environmental heat			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 August, 19 66 , to 28 May, 19 67 , that (I) (we) last saw the deceased alive on 28 May 19 67 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Ernest N. Moss		22b. DATE SIGNED 27 June 1967	
22c. PHYSICIAN'S NAME (Type) ERNEST N. MOSS, LTC, MC		22d. ADDRESS USA Dispensary, Edgewood Arsenal	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 29 May 1967	
23c. NAME OF CEMETERY OR CREMATORY Tifereth Israel Anshe Sfard Cemetery		23d. LOCATION (City, town or county) (State) Rosedale (Balto. Co.) Md.	
24. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Rd. Baltimore, Maryland		25a. REC'D BY REGISTRAR JUN 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1859

bioRxiv preprint doi: <https://doi.org/10.1101/000000>; this version posted November 1, 2014. The copyright holder for this preprint (which was not certified by peer review) is the author/funder, who has granted bioRxiv a license to display the preprint in perpetuity. It is made available under aCC-BY-NC-ND 4.0 International license.

• **Scopolamine**

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06740

06727

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY in 1b <u>DDA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Don Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thelma A. Moore</u>		4. DATE OF DEATH <u>May 1 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	9. AGE (In years lost birthday) <u>53</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William P. Hawley</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-0542</u>	
17. INFORMANT <u>Edward E. Moore, Perryville, Md. 21903</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be/A</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer - M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>5-1-67</u>	
23a. BURIAL, CREMATION, or MOVING (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/4/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Md. Cecil</u>
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Md.</u>		25. REC'D BY REGISTRAR <u>1967</u>	
		25b. SIGNATURE OF REGISTRAR <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 2DM 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
06741											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Harford Grace</u>						c. LENGTH OF STAY IN b. <u>95 yrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.O. # 2 Box 21078</u>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L.</u> Last <u>Ostorn</u>						4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 20, 1871</u>		9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George V. Ostorn</u>						14. MOTHER'S MAIDEN NAME <u>Martha Margaret Thompson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>220-30-3880</u>		17. INFORMANT <u>Mrs. Corinna S. Hines</u> Address <u>118 Frances St. Harford, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> DUE TO (b) <u>Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1940</u> , 19 <u>57</u> , to <u>5-27-67</u> , that (I) (we) last saw the deceased alive on <u>5-26-67</u> , and that death occurred at <u>5-27-67</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>R. S. Louie</u>						22d. ADDRESS <u>Harford Grace Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Whiskeyan Chapel Cem.</u>		23d. LOCATION (City, town or county) <u>Harford Co.</u>		23e. (State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harford Grace Md.</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

85100

CHICAGO, ILL.

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06742

CERTIFICATE OF DEATH

06729

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Grounds</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Grounds</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kirk Army Hospital</u>		d. STREET ADDRESS <u>2728 c west Court St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Janet</u> Middle <u>M</u> Last <u>PAPE S</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 Aug 64</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A Infant</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Md.</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>William A. Papes</u>		15. MOTHER'S MAIDEN NAME <u>Margaret Richer</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>None</u>	
18. INFORMANT <u>Mother,</u>		Address <u>Same as 2 C & D</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma, metastatic</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>13 May</u> , 1967, to <u>13 May</u> , 1967, that (I) (we) last saw the deceased alive on <u>13 May</u> , 1967, and that death occurred at <u>1:09 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leland W. Wight Jr.</u>		22b. DATE SIGNED <u>13 May 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leland W. Wight Jr. M.D.</u>		22d. ADDRESS <u>Aberdeen Proving Ground, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/16/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Ft. Meyer, Va.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Walter W. Wight Jr.</u>		25. REC'D BY REGISTRAR DATE <u>MAY 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jorgensen</u>			

02745

OFFICE OF DEATH

02745

None

2/1/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06743

CERTIFICATE OF DEATH

06730

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>2 hrs 30 min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAGNOLIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>512 Dembytown Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Willie</u> First Middle Last		4. DATE OF DEATH <u>MAY 4</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1914</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgetown, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie Porcher, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Janie Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>249-07-5170</u>	
17. INFORMANT <u>Mrs. Mary Peters Porcher, 512 Dembytown Rd</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Anterior Coronary</u> DUE TO <u>thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>3-4 yrs</u> (c) <u>Old posterior Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old posterior Coronary thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1, 1966</u> to <u>MAY 4, 1967</u> that (I) (we) last saw the deceased alive on <u>MAY 4, 1967</u> , and that death occurred at <u>11 PM</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>5/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>HAUCE DE GRACE, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Baptist Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Magnolia Harford Md</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. DATE <u>MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 5-63

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>06744</p> </div> <div> <p>CERTIFICATE OF DEATH</p> <p>06731</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fallston			c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Fallston Road					d. STREET ADDRESS (P.O. Box #63) Old Fallston Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Heidi Quesinberry					4. DATE OF DEATH Month May Day 25 Year 19 67				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1962		9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months 4 Days 12		IF UNDER 24 HRS. Hours 12 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Maricopa, Co., Arizona		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Quesinberry Lonnie Ray Quesinberry, Jr.					14. MOTHER'S MAIDEN NAME Ruth Ann Pierce				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT (Father) 838-9245 Mr. L. Ray Quesinberry, Jr.		P.O. Box #63 21047 Fallston, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Neoplasm, Malignant DUE TO 1930 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this-hospital) attended the deceased from <u>FEB.</u> <u>1967</u> to <u>5/25/</u> <u>1967</u>, that (I) (we)-last saw the deceased alive on <u>5/25/</u> <u>1967</u>, and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE Kermit P. Bonovich					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 25, 1967
22c. PHYSICIAN'S NAME (Type) Kermit Bonovich					22d. ADDRESS 879-0717 Fallston, Maryland 21047				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Ch. Cem.		23d. LOCATION (City, town or county) (State) Joppa, Harf. Co., Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE Joseph William Foster					25a. REC'D BY REGISTRAR MAY 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

Joseph William Foster

00714

London

London

2 months

London

(P.O. No. 100)
Old London Road

Old London Road

White

White

June 1, 1962

White

none

none

London, Co., London

U.S.A.

London, Co., London

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(P.O. No. 100)

London, Co., London

none

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H.S.

London

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May 20, 1962 London, Co., London

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06745

CERTIFICATE OF DEATH

06732

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pylesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fawn Grove	
c. LENGTH OF STAY IN 1b 3 Mos.		d. STREET ADDRESS 153	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Violet Middle Viatrce Last Roberts		4. DATE OF DEATH Month May Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1910
9. AGE (In years lost birthday) yrs. 56		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther Perkins		14. MOTHER'S MAIDEN NAME Pearl Cochran	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 234-54-2975	
17. INFORMANT Mrs. Marie Measley, Pylesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1, 1967 to May 1, 1967 , that (I) (we) last saw the deceased alive on May 1, 1967 , and that death occurred at 5:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Joseph A Hunt MD		22b. DATE SIGNED 5/2/67	
22c. PHYSICIAN'S NAME (Type) Joseph A Hunt MD		22d. ADDRESS Delta, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/4/67	23c. NAME OF CEMETERY OR CREMATORY Norrisville	23d. LOCATION (City or Town) (County) (State) Norrisville, Harford Co. Md.
24. FUNERAL DIRECTOR Benjamin O. Chubb		25a. REC'D BY REGISTRAR MAY 4 1967	
ADDRESS Stewartstown, Pa.		25b. REGISTRAR'S SIGNATURE John J. Judge	

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STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06733

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. LENGTH OF STAY IN IB 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital			d. STREET ADDRESS (Wheel Road) Route 3, Box 335		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) CHARLES Frederick SANDERS			4. DATE OF DEATH Month May Day 29 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1948	9. AGE (In years lost birthday) 18 yrs.	IF UNDER 1 YEAR Months 18 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TREE TRIMMER		10b. KIND OF BUSINESS OR INDUSTRY Asplundh Tree Exp. Co.		11. BIRTHPLACE (State or foreign country) Baltimore City, Maryland	
13. FATHER'S NAME William Dennis Sanders			14. MOTHER'S MAIDEN NAME Grace Taylor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-50-6177		17. INFORMANT (Name) Mrs. Grace T. Sanders Address 218-50-6177, Box # 335, Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Salicylate Overdose 9705 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested overdose of aspirin			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5/27 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat White <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
		20f. (City or town) Bel Air (Harford) Maryland		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 5/29/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Meth. Ch. Cem.	
		23d. LOCATION (City or Town) Emmorton, Harford Co., Maryland		(County) (State)	
24. FUNERAL DIRECTOR Joseph William Foster		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR DATE JUN 1 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Harve de Grace						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Harve de Grace					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Citizens Nursing Home						d. STREET ADDRESS 4113 Hamilton Avenue					
3. NAME OF DECEASED (Type or print) Marie R. Schutz						4. DATE OF DEATH Month 5 Day 25 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-12-1903		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John R. Hecker						14. MOTHER'S MAIDEN NAME Mary J. Murphy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr Norval Schutz		Address 4113 Hamilton Avenue #6					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus										INTERVAL BETWEEN ONSET AND DEATH One Year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from December 5-23-1967 to 5-25-1967 , that (I) (we) last saw the deceased alive on 5-23-1967 , and that death occurred at 5:05 PM , from the causes and on the date stated above.											
22a. SIGNATURE Peter P. Rodman, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-26-67			
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.						22d. ADDRESS 8 Law St., P.O. Box 548, Aberdeen, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-27-1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home						ADDRESS 7401 Belair Road		25a. REC'D BY REGISTRAR MAY 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 06735

1. PLACE OF DEATH a. COUNTY <u>H&T Ford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence or other address) a. STATE <u>MD.</u> b. COUNTY <u>H&T Ford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY in lb <u>8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		d. STREET ADDRESS <u>Box 486</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Junior Mason</u> First Middle Last <u>H. Simmons</u>		4. DATE OF DEATH <u>May 22</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-24</u> 43
9. AGE (In years lost birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH STATE MARSHAL CO W. Va</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Z. L. Simmons</u>		14. MOTHER'S MAIDEN NAME <u>BERTIE L. MASON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT <u>Mr Dewell Loyden</u>		Address <u>108 Washington Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia Due to Drowning</u> <u>975X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped off JFK Bridge</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-10-5-19 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>JFK Bridge</u>	20f. (City or town) (County) (State) <u>Havre de Grace Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		22. DATE SIGNED <u>5-22-67</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>5/23/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LIMESTONE CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>MOUNDSVILLE MARSHAL W. VA</u>
24. FUNERAL DIRECTOR <u>Pennington & Son Havre de Grace Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>MAY 29 1967</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06748

CERTIFICATE OF DEATH

06736

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUTE DE GRACE</u>		c. LENGTH OF STAY IN lb <u>3 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		d. STREET ADDRESS <u>Apt # 33</u> <u>126 Hickory Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BREVIN Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Albert Simon</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 22, 1882</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Simon</u>		14. MOTHER'S MAIDEN NAME <u>L. Elizabeth Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>716-09-4931</u>	
17. INFORMANT (with Address) <u>Mrs. Elizabeth P. Simon</u> <u>126 Hickory Ave. Apt. 33</u> <u>Bel Air, Maryland 21014</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Pyelonephritis</u> DUE TO (c) <u>old age</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1.5 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1967</u> to <u>4-30, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-30, 1967</u> , and that death occurred at <u>7:30 A.M.</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>John D. Yan M.D.</u>		22b. DATE SIGNED <u>May 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Yan M.D.</u>		22d. ADDRESS <u>615 S. Union Ave., Haute de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 3, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Spring Episcopal Ch. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Forest Hill, Harf. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>W. Broadway & Williams St.</u> <u>Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

08157

SECTION OF DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06737

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUREDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>57 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>A</u> Middle <u>SMITH</u> Last		4. DATE OF DEATH <u>MAY 13</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cable Splicer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Govt - Ret.</u>	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Gregory Smith</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>1928-1940</u>		16. SOCIAL SECURITY NO. <u>214-26-8923</u>	
17. INFORMANT <u>Mrs. Katherine I. Smith, 4004 Phila. Rd.</u>		Address <u>Abingdon, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>Arteriosclerotic CV Disease</u> (b) <u>Deplete Myelitis</u> DUE TO <u>Deplete Myelitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 19, 1942</u> to <u>MAY 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>MAY 13, 1967</u> and that death occurred at <u>6:05 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph Hinky MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph Hinky MD</u>		22d. ADDRESS <u>Churchville Hwy. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 16, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Md</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25. REC'D BY REGISTRAR <u>MAY 15 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10770

DEPARTMENT OF HEALTH

10770

Dr. J. H. Harkins
Dr. J. H. Harkins
Dr. J. H. Harkins

Dr. J. H. Harkins
Dr. J. H. Harkins
Dr. J. H. Harkins

Dr. J. H. Harkins MD
Dr. J. H. Harkins MD
Dr. J. H. Harkins MD

06751

CERTIFICATE OF DEATH

06738

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 109 Holloway Lane	
3. NAME OF DECEASED (Type or print) First JOHN Middle A. Last STAPLES		4. DATE OF DEATH Month May Day 23 Year 19 67	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Nov. 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad (Ret.)	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reuben Staples (D)		14. MOTHER'S MAIDEN NAME Elizabeth Thomas (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-12-7880	
17. INFORMANT Betty Gompers, Aberdeen, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-15-67 , 19 67 , to May 23, 1967 , that (I) (we) lost saw the deceased alive on May 23, 1967 , and that death occurred at 8:17 PM from causes and on the date stated above.			
22a. SIGNATURE B.J. Plunkett Jr.		22b. DATE SIGNED 5-24-67	
22c. PHYSICIAN'S NAME (Type) B.J. Plunkett Jr., M.D.		22d. ADDRESS 617 W. Bel Air Ave. Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 29 May 67	23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens, Aberdeen, Maryland	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Tarring Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 26 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06752 Item #2b,c,&d Film #0390 6/23/57 re						06739					
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Near Edgewood</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewood / Towson</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>(Mrs. Strong Nursing Home) Old Emorton Rd.</i>						d. STREET ADDRESS <i>Shealey Ave. Sdldgld Nldldld Home</i>					
3. NAME OF DECEASED (Type or print) <i>Edward A. Steuart</i>						4. DATE OF DEATH Month <i>May</i> Day <i>4</i> Year <i>67</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1883</i>		9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stationary Engr. -ret.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>General Institutions</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Richard S. Steuart</i>						14. MOTHER'S MAIDEN NAME <i>Mary Bosley</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16. SOCIAL SECURITY NO. <i>1</i>		17. INFORMANT <i>Family records</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic CV Disease</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>1-1</i> , 19 <i>66</i> , to <i>5-4</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-1</i> , 19 <i>67</i> , and that death occurred at <i>6A</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Gerald E. Palmer</i>								22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Gerald E. Palmer M.D.</i>						22d. ADDRESS <i>Bel Air - Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 6, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Maria Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Towson, Maryland</i>					
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>						25a. REC'D BY REGISTRAR DATE <i>MAY 8 1967</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

00110

00110



00110

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06753

05740

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Burlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground			c. LENGTH OF STAY IN 1b 2 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverside		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital				d. STREET ADDRESS 512 Monroe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle J. Last STOER				4. DATE OF DEATH Month May Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1947		9. AGE (In years lost birthday) 19 yrs.		10. IF UNDER 1 YEAR Months 15 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier			10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Benjamin Stoer				14. MOTHER'S MAIDEN NAME Loretta McCay			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 136-40-1755		17. INFORMANT DA 41 Personnel Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Injuries to head DUE TO intra-thoracic organs and intra-abdominal organs CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (b) Automobile Accident (c) Automobile Accident							INTERVAL BETWEEN ONSET AND DEATH 3 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was the driver of an auto involved in an accident.				
20c. TIME OF INJURY Month Day Year Hour 1:00 P.M. May 15 19 67			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) JFK Hwy Rte 95		20f. (City or town) (County) (State) Whitemarsh, Baltimore, Md.
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 15 , 19 67 , to May 15 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on May 15 , 19 67 , and that death occurred at 4:00 AM , from causes and on the date stated above.							
22a. SIGNATURE Thomas Fraher MD				22b. DATE SIGNED 15 May 1967		22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, M.D.	
22d. ADDRESS Kirk Army Hospital, APG, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 19, 1967		23c. NAME OF CEMETERY OR CREMATORY Beverly National Cemetery		23d. LOCATION (City or Town) (County) (State) Beverly, New Jersey	
24. FUNERAL DIRECTOR Lee A. Patterson & Sons				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03753

REPORT NO. 10

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06754

CERTIFICATE OF DEATH

06741

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u> Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de Grace</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		d. STREET ADDRESS <u>1087 Ave D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Posey</u> Middle <u>Grover</u> Last <u>Sumpter</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1890</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Prov. Gnd.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph G. Sumpter</u>		14. MOTHER'S MAIDEN NAME <u>Martha Allie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-01-8655</u>	
17. INFORMANT <u>Mrs. Maggie M. Sumpter, Perry Point, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> DUE TO (b) <u>Generalized Arterio sclerosis</u> DUE TO (c) <u>and ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 10, 1967</u> , to <u>May 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 12, 1967</u> and that death occurred at <u>6:20 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips</u> M.D.		22b. DATE SIGNED <u>5/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>DARLINGTON 2nd</u>	
23a. BURIAL, CREMATION, or other disposition <u>Buried</u>	23b. DATE THEREOF <u>May 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Maryland.</u>
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Maryland.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05241

92754

1 day

Dec. 3, 1870

Virginia

Franklinville

Franklinville, Virginia, Dec. 3, 1870

715-01-2572

no

Franklinville, Virginia

Franklinville, Virginia

Franklinville, Virginia

Franklinville, Virginia

Franklinville, Virginia

Franklinville, Virginia

Franklinville, Virginia

Franklinville, Virginia

06755

CERTIFICATE OF DEATH

06742

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>N. Ridgely Rd. R.D. #2</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian C. Teyhan</u>		4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1905</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
13. FATHER'S NAME <u>John R. Culp</u>		14. MOTHER'S MAIDEN NAME <u>Laura Alice Hefley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>250-34-3981</u>	
17. INFORMANT <u>Husband</u> <u>338-7668</u> Address <u>Northridge Drive, Box #2, North 14, Cedar-Lane, Bel Air, Maryland 21014</u>		18. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>4201</u> (b) <u>Coronary thrombosis</u> DUE TO <u>4-6 hrs</u> (c) <u>Arteriosclerotic Cardiovascular Disease 3 years</u> Interval between onset and death <u>4-6 hrs</u>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	24. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	26. (City or town) (County) (State)
27. I certify that (I) (this hospital) attended the deceased from <u>May 29th, 1967</u> to <u>May 31, 1967</u> that (I) (we) last saw the deceased alive on <u>May 31, 1967</u> and that death occurred at <u>4:30 P.M.</u> from causes and on the date stated above			
28. SIGNATURE <u>Edward C. Loo</u> M.D.		29. DATE SIGNED <u>5/31/67</u>	
30. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		31. ADDRESS <u>Harre-de-Grace, Md.</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	33. DATE THEREOF <u>JUNE 2, 1967</u>	34. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	35. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co, Maryland 21014</u>
36. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway & Williams St, Bel Air, Maryland 21014</u>		37. REC'D BY REGISTRAR <u>Charles J. Jones</u> 38. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

001770

GROUP 10 OF 1000

001770

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06756

06743

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEL AIR (RURAL)		c. LENGTH OF STAY IN 1b 18 YRS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BEL AIR (RURAL)		d. STREET ADDRESS RD#2 Box 289 SHUCKS CORNER	
3. NAME OF DECEASED (Type or print) RICHARD COULSON TODD				4. DATE OF DEATH MAY 31 1967		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Sep. 1904	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Perryville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT TODD				14. MOTHER'S MAIDEN NAME Margaret Coulson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 197-07-9737		17. INFORMANT GRACE TODD (WIFE) Address SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) ACUTE CORONARY OCCLUSION DUE TO HR01 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH LESS THAN 10 MIN.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Philip W. Heuman M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		31 MAY 1967 DATE SIGNED			
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		307 HICKORY AVE BEL AIR, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 June 67		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Maryland		22d. LOCATION (City, town, or country) _____ (State) _____	
23. FUNERAL DIRECTOR Walter Macomber Jr.		Tarring Funeral Home Aberdeen, Maryland		24a. REC'D BY REGISTRAR JUN 5 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	

00130

00130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
06757								06744	
1. PLACE OF DEATH a. COUNTY		131 S. Union Avenue							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HARFORD MARYLAND							
c. LENGTH OF STAY IN b.		3 YRS							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		131 So. Union Ave.							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
Elijah		J.		Vanover		5		9 1967	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
male		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4-26-1909		58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
SEALINE BURNER OPERATOR SHIPYARD				KENTUCKY		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
JOSEPH G. VANOVER		NANCY TOLLIVER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		301-01-6959		Mr. Emigino M. VANOVER		HAYREDE GRACE		MD 21078	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1621		Respiratory Insufficiency				1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		mediastinal metast.					
		(c)		Bronchiolar Carcinoma				3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19									
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at 10:20 P.M., from the causes and on the date stated above.									
22a. SIGNATURE		22b. DATE SIGNED							
Stephen Turbin		5-9-67							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
STEPHEN TURBIN		131 South Union Avenue							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
BURIAL		MAY 12, 1967		MEADOWBRIDGE MEMORIAL PARK BALTO. CO.		BALTO. CO.		MD	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
R. MADISON MITCHELL		HAYREDE GRACE, MD		MAY 12 1967		Charles Judge			

14330

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND											
CERTIFICATE OF DEATH											
06758											
06745											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street</u>			c. LENGTH OF STAY IN 1b <u>10 mos.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street</u> <u>12-1</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 254 A</u>					d. STREET ADDRESS <u>Box 254 A</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>C.</u> Last <u>Walton</u>					4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-5-1920</u>		9. AGE (In years last birthday) <u>46 yrs.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bel-Air, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Glasco A. Davis</u>					14. MOTHER'S MAIDEN NAME <u>Edna Williams</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>216-12-0306</u>		17. INFORMANT <u>Mr. Clarence E. Walton</u>			Address <u>Box 254 A Street, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant hypertension</u> DUE TO (c) <u>Arteriosclerotic cardio cerebrovascular disease</u>									INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>15 yr.</u> <u>15 yr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>57</u> , to <u>12 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12 May</u> , 19 <u>67</u> , and that death occurred at <u>5:40 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edwin W. Whiteford Jr. M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>16 May 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edwin W. Whiteford Jr. M.D.</u>					22d. ADDRESS <u>Whiteford, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-17-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove A.M.E. Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Rocky, Harford Co. Md.</u>				
24. FUNERAL DIRECTOR <u>Otelia J. Bullock, Harre de Grace, Md.</u>					ADDRESS <u>556 Xerxes St.</u>		25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Have de Grace</u>		c. LENGTH OF STAY IN 1b <u>51 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>SCOTT</u> Last <u>WHITE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 22/1874</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penn. Lancaster Co. Pa. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William K. White</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jamison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-20-6426</u>	
17. INFORMANT <u>Merton White</u>		Address <u>Rising Sun, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac - Renal decompensation</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>67</u> , to <u>5/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5/31</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A.W. Grigoleit</u>		22b. DATE SIGNED <u>5/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGOLEIT</u>		22d. ADDRESS <u>Have de Grace, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6-3-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rosebank Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Calvert Cecil Md.</u>
24. FUNERAL DIRECTOR <u>Lemon E. W. Miller</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUN 5 1967</u>	

1925

CHICAGO, ILL.

1925

NOTE: This is a copy of the original manuscript of the book "The History of the University of Chicago" by Robert Maynard Hutchins. The original manuscript is in the possession of the University of Chicago Library. The copy was made by the University of Chicago Library in 1925.

The University of Chicago Library is pleased to have this copy of the original manuscript of the book "The History of the University of Chicago" by Robert Maynard Hutchins. The original manuscript is in the possession of the University of Chicago Library. The copy was made by the University of Chicago Library in 1925.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06760

CERTIFICATE OF DEATH

06747

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 23 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS 42 Monroe Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPHINE WILLIS		4. DATE OF DEATH Month May Day 29 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Aug. 1868
9. AGE (In years last birthday) yrs. 98		IF UNDER 1 YEAR Months 29 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mozella Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-52-7886	
17. INFORMANT Elsie W. Ames, Aberdeen, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO C.U.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MALNUTRITION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 7, 19 67 , to May 29, 19 67 , that (I) (we) last saw the deceased alive on May 29, 19 67 , and that death occurred at 6:45 M. PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Santiago Leyte-Vidal</i>		22b. DATE SIGNED 5-31-67	
22c. PHYSICIAN'S NAME (Type) Santiago Leyte-Vidal, M.D.		22d. ADDRESS 114 W. Bel Air Ave. Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3 June 67	
23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery, Aberdeen, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Walter Macomber Jr.</i>		25a. REC'D BY REGISTRAR DATE JUN 2 1967	
25b. REGISTRAR'S SIGNATURE <i>John L. Judge</i>			

06741

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